

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 005616	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/08/2012
NAME OF PROVIDER OR SUPPLIER BRIDGE AT GARDEN PLAZA			STREET ADDRESS, CITY, STATE, ZIP CODE 8614 W 10TH ST INDIANAPOLIS, IN 46234		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
{R 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on 12/21/11.</p> <p>Survey dates: February 7,8, 2012</p> <p>Facility Number: 005616 Provider Number: 005616 AIM Number N/A</p> <p>Survey team: Patti Allen, BSW TC Marcy Smith, RN Leia Alley, RN (February 7, 2012) Dinah Jones, RN</p> <p>Census bed type Residential: 90 Total: 90</p> <p>Census payor type: Other: 90 Total: 90</p> <p>Sample : 5</p> <p>Bridge at the Garden Plaza was found to be in compliance with 410 IAC 16.2 in regard to the Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on 12/21/11.</p> <p>Quality review completed on February 10, 2012, by Bev Faulkner, RN</p>	{R 000}			

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TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

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If continuation sheet 1 of 1